DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEC 10 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345460	A. BUILDING ______ B. WING ______	11/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUILFORD HEALTH CARE CENTER	2041 WILLOW ROAD GREENSBORO, NC 27406

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to notify the attending physician that	F 157	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F157 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** Resident #131: MD order dated 11/8/12 to discontinue morning dose of Lorazepam 1 mg.	12/07/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/5/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 anti-anxiety medication was held for sedation on multiple occasions for 1 of 10 sampled residents whose medications were reviewed (resident #131). Findings include: Resident #131 was admitted to the facility on 7/26/11 with multiple diagnoses including anxiety, insomnia, psychosis, severe dementia with delusional features, and history of falls. Review of the resident's clinical record revealed physician orders dated 8/21/12 for lorazepam (anti-anxiety) 1mg (milligram) topically twice daily, orders dated 4/9/12 for trazodone (antidepressant, sedative) 100mg every night at bedtime, orders dated 7/11/12 for hydroxyzine (antihistamine, sedative) 50mg every night at bedtime, and orders dated 9/25/12 for Seroquel (antipsychotic) 25mg every night at bedtime. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "Ativan (lorazepam) - Warnings/Precautions - use with caution in elderly or debilitated patients...causes CNS (central nervous system) depression resulting in sedation, dizziness, confusion, or ataxia. Drug interactions - other CNS depressants may increase the CNS effects of lorazepam. Desyrel (trazodone) - Warnings/Precautions - trazodone frequently causes sedation...sedative effects may be additive with other CNS depressants. Hydroxyzine - Warnings/Precautions - causes sedation...sedative effects of CNS depressants are potentiated. Seroquel (quetiapine) - Adverse effects - greater than 10% - somnolence. Drug interactions - quetiapine increases levels of lorazepam. The effects of other centrally-acting drugs may be potentiated by quetiapine."	F 157	**F157 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** Licensed Nurses will be re-educated on MD notification for any residents medication not administerred for 3 consecutive days. All residents' medication administration records will be audited during monthly transition of residents' MAR by administrative nursing staff (DON, Unit Managers, and SDC nurse) to ensure accuracy of all physician orders by 12/1/12.	12/07/2012

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F 157	Continued From page 2 Review of the minimum data set (MDS) dated 9/18/12 revealed the resident was severely cognitively impaired. The MDS revealed the resident required extensive assistance with his activities of daily living. Review of the resident's care plan dated 9/25/12 revealed approaches which included monitor for adverse reaction to medications (dizziness, drowsiness, orthostatic hypotension, changes in behavior, insomnia). Review of the resident's October 2012 medication administration record (MAR) revealed a hand written entry dated 10/3/12 below the lorazepam order which read "hold for sedation." Review of the MAR revealed the 8AM dose of lorazepam was held from 10/4/12 - 10/31/12, as indicated by the nurses' initials being circled. The 9PM dose of lorazepam was held on 10/16/12, 10/18/12, 10/19/12, 10/20/12, 10/21/12, 10/28/12, 10/29/12, and 10/30/12. Review of the MAR revealed Seroquel 25mg was given nightly at 8PM. The MAR revealed trazodone 100mg was given nightly at 10PM. The MAR revealed hydroxyzine 50mg was given nightly at 8PM until it was discontinued on 10/25/12. Review of the October 2012 nursing notes revealed no documentation regarding the resident's sedation, his medication being held, or that the physician had been notified. In an interview on 11/8/12 at 3:09PM, Nurse #1 stated if the nurses' initials were circled on the MAR, it meant the medication was held. She reviewed the resident's October MAR and stated the lorazepam was held due to sedation. She	F 157	**F157 Measures to be put in place or systemic changes made to ensure practice will not re-occur:** Transition to electronic MARS will be completed by 12/31/12. Chart Checks will be done daily M-F by Unit Managers to include review of all new orders, discontinued orders, draft orders and medications not administered. DON/and or Unit Managers will audit MAR 10% sample of census X 2 weekly X 4 weeks, X1 weekly X 4, and monthly X 1 for accuracy of MAR and MD notification as needed.	12/07/2012

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F 157	Continued From page 3 wasn't sure what the facility policy was but stated her nursing judgment was to call the physician if a medication was held for three consecutive days. In an interview on 11/8/12 at 5:40PM, Nurse #2 stated the nurses' initials being circled on the MAR indicated the medication was held. She stated the resident's lorazepam was usually given after his other medications. If the resident was asleep she would not awaken him to give the medication. The nurse stated she was aware the resident's other medications may also cause sedation. Nurse #2 stated she would hold medication for "3 days at the most, then I'd call the physician." In an interview on 11/8/12 at 3:56PM, the Director of Nursing (DON) stated the nursing staff was trained at orientation by the staff development coordinator. She reviewed the resident's October MAR and stated the nurses' initials being circled meant the medication was held. The facility policy was to notify the physician if a medication was held for three consecutive days. The nursing staff was also supposed to document held doses and sedation in the nursing notes. The DON stated she expected the staff to know the side effects of the medications they administered. Her expectation was for the staff to notify the physician if a resident had continuous sedation. She expected the staff to notify the physician if medication was held for three days. The nurse responsible for giving the resident's morning medications was unavailable for interview. Record review revealed a physician's order dated	F 157	**F157 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:** Chart Checks will be done daily M-F by Unit Managers to include review of all new orders, discontinued orders, medications not administered, and draft orders. DON/and or Unit Managers will audit MAR 10% sample of census X 2 weekly X 4 weeks, X1 weekly X 4, and monthly X 1 for accuracy of MAR and MD notification as needed. Plan of Correction/Audit results to be discussed in weekly QA Risk Management meeting and Quality Assurance Committee meeting X 1 quarter for further intervention if needed.	12/07/2012

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F 157	Continued From page 4 11/8/12 to discontinue the morning dose of lorazepam 1mg.	F 157		12/07/2012
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews, facility policy review, resident interviews and staff interviews the facility failed to provide supervised smoking for residents that were assessed to require supervision while smoking. This was evident for 2 of 2 residents observed smoking unsupervised. (Resident #81 and Resident #40) Findings included: 1 According to the Minimum Data Set (MDS) dated 11/08/12 Resident # 81 was admitted with cumulative diagnoses of non Alzheimer ' s dementia, schizophrenia and anxiety. According to the BIMS (brief Interview for mental status) he was cognitively intact and he was alert and oriented and was able to make decisions independently. He required minimal assistance from the staff for all activities of daily living including assistance when ambulating. A review of Resident #81's care plan dated 09/05/12 revealed " resident is non-compliant with smoking. " The approaches/Interventions	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

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F 323	Continued From page 5 dated 09/05/12 revealed the resident will wear apron when smoking, offer alternatives to smoking as ordered by the doctor, the resident will not have ignition sources in his possession, resident will smoke supervised at designated times of before and after each meal. Resident will only smoke in designated area. A review of the Psychiatry Evaluation and Management for Resident #81 on 10/04/12 revealed the doctor documented " the patient extremely declined " . An assessment on 11/5/12 revealed staff requested a visit secondary to increased psychosis, talking to self worse than baseline in patient with chronic schizophrenia. Resident # 81 was assessed to have moderately impaired recent memory and judgments. A review of the Safe Smoking Assessment completed on 10/25/12 for Resident # 81 revealed, " under Cognition Function, the resident had no short term or long term memory and poor ability for memory recall. " He did not communicate effectively with others and demonstrated unsafe technique for putting out matches or lighter and disposing of the ash. The IDT (interdisciplinary team) determined he was an unsafe smoker requiring constant supervision. A review of the facility's Patient Smoking Acknowledgement dated 10/25/12 was signed by the resident. During an interview with SW #1 on 11/08/12 at 3:55 PM indicated she explained the smoking policy to Resident #81 and he stated he understood, so she instructed him to sign the form. She further indicated the staff must remind him about the smoking policy because he did not remember that he needed to be supervised when he smoked. Resident # 81 was observed sitting in the corner	F 323	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	12/07/2012

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F 323	Continued From page 6 in a chair in the courtyard alone smoking on 11/06/12 at 2 PM and on 11/07/12 at 4:46 PM. There was no staff member sitting with this resident while he was smoking. Resident # 81 was not wearing a protective apron. There was no staff member observed to be sitting with the resident while he was in the courtyard when observations were made. Resident # 81 was observed on 11/07/12 at 12:48 PM to be in the courtyard with no staff supervision, no smoking vest as he was smoking a cigarette. Resident # 81 stated "I enjoy sitting outside all day." On 11/07/12 at 3:00 PM while interviewing Nurse #1, she interrupted the interview and went out in the smoking courtyard and removed a partially lit cigarette from resident #40 as he was in the process of lighting a cigarette from another resident's (Resident # 81), cigarette butt (approx 1 inch in length) while sitting in the courtyard. As Nurse #1 was taking the partially lit cigarette from Resident #40, Resident #81 grabbed the 1 inch cigarette butt and took a drag from the cigarette butt. Nurse # 1 stated " they are supposed to be supervised when they smoke and there is no staff in the courtyard. " Resident # 40 was noted to have a smoking apron folded on the back of his wheelchair. Resident # 81 did not have a smoking apron. Nurse #1 repeated resident #40 " is supposed to be constantly supervised and wearing an apron. " She wheeled resident #40 back to the nurses' station leaving resident # 81 in the courtyard smoking his cigarette. During an interview with Nurse #1 on 11/07/12 at 3:10 PM she indicated she should have brought Resident # 81 back in the facility too.	F 323	**1. F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** -Resident # 81: SW met with resident and RP and reviewed smoking policy, signed acknowledgement and need for supervised smoking 11/8/12. Resident informed cannot sit in smoking courtyard without supervision, but can sit outside in non smoking courtyard and on front porch at any time, and can sit in smoking courtyard when supervised. -Resident #40: SW met with resident and RP and reviewed smoking policy, signed acknowledgement and need for supervised smoking 11/8/12 -11/8/12 Staff member assigned to smoking courtyard M-F 10am-5pm -11/7/12 Licensed Nurse and or CNA responsible to check smoking courtyard to verify that resident #81 and resident #40 are not smoking unsupervised and document findings.	12/07/2012

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F 323	Continued From page 7 An interview with the administrator on 11/07/12 at 4:00 PM revealed on 10/25/12 all the residents who were smokers and even all the non smokers were in serviced regarding the new smoking policy and rules. All residents that were smokers were assessed; using a safe smoking assessment and each resident signed the smoking acknowledgement which indicated they were aware of the rules and would follow them. Then all staff and family members including the responsible parties were notified of the smoking policy. The resident ' s smoking assessments were added to the care plans. They (all residents and families) were told not to share cigarettes, and the ignition sources were all to be kept at the Nurse ' s station. The staff was supposed to be checking the courtyard every 15 minutes to make sure there is no resident outside who needed constant supervision while smoking. The administrator stated " Resident #40 must have begged Resident # 81 for a cigarette and he gave him one. " She continued the Social Worker spoke with both residents and since they had signed off on the acknowledgement, they will be issued a 30 day d/c (discharge) notice. The family members will be contacted that the residents will be d/c in 30 days. The administrator reviewed the smoking assessment for Resident # 81 and it indicated the resident was to have constant supervision while smoking. The administrator explained constant supervision meant he was to wear a smoking apron and a staff member was to be with him at all times when he was smoking. She stated " He liked to sit outside so we let him sit out in the courtyard. " The staff provided his cigarettes and ignition source when it was time for him to smoke. The administrator indicated Resident # 81 told her he took the cigarette butt	F 323	-Unit education on Smokers needing supervision, smoking times, and/or smoking aprons was done 10/25/12; and 11/8/12. -Resident #81 and Resident #40 assigned designated smoking times for periods when no staff member assigned to smoking courtyard "offered supervised smoking after meals and at HS". - Care plans for each resident who were assessed as needing supervision when smoking were re-checked and updated on 12/5/12 by Nurse Consultant. **2. F323 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** -11/8/12 Staff member assigned to smoking courtyard M-F 10am-5pm -11/7/12 Licensed Nurse and or CNA responsible to check smoking courtyard every 15 minutes on Saturday, Sunday and 5pm to 10am M-F to verify that resident #81 and resident #40 are not smoking unsupervised and document findings.	12/07/2012

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F 323	Continued From page 8 out of the smoking tower and was smoking it and he did not give a cigarette to Resident # 40. She was unsure how Resident # 81 got the lit cigarette or the cigarette resident # 40 was trying to light. An interview with the resident on 11/08/12 at 8:55 AM revealed he was sitting in his room. He stated " I cannot go outside because I am not allowed to be outside alone, my brother was outside yesterday and they (staff) told him I would be kicked out if he smoked outside again. " He further indicated he did not know about new smoking rules or that he needed to have someone with him. He enjoyed being outside to receive his blessings. An interview with the administrator on 11/08/12 at 9:05 AM explained Resident # 81 told her he took the lit butt out of the cigarette tower and started smoking it when he gave it to Resident # 40. The administrator attempted to demonstrate how Resident # 81 took the one inch lit cigarette butt out of the smoking tower. She was unable to take a butt out of the tower because once the butt is put in the tower the cigarette butt falls to the bottom of the tower. The administrator indicated the 30 day discharge notice was rescinded due to a systems error they are trying to resolve. 2. According to the minimum data set (MDS) assessment dated 2/12 Resident # 40 was admitted with cumulative diagnoses of CVA (cerebral vascular accident) with right sided weakness, anxiety and depression. He scored a 4 on the BIMS (brief Interview for mental status) indicating he had poor short and long term memory deficits. He was dependent on the staff for all activities of daily living including transfers	F 323	-11/30/12 another meeting held by SW and Administrator with all smokers and their responsible parties to review smoking policy and signed acknowledgement form. This included "No resident and/or family members of residents would be permitted to share smoking materials with other residents" -Residents identified as needing supervised smoking, designated times, use of apron will be added to Unit Device list available for all staff daily at nurse's station in folder. UM will be responsible to keep this updated with any changes daily. -Residents identified as needing supervised smoking will have cigarettes and ignition source kept on nurse's cart. - Care plans for each resident who were assessed as needing supervision when smoking were re-checked and updated on 12/5/12 by Nurse Consultant.	12/07/2012

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F 323	Continued From page 9 and mobility. Review of the Safe Smoking Assessment completed on 10/25/12 for Resident #40 revealed " under cognition status; the resident had short term or long term memory and poor ability for memory recall. " Resident #40 was unable to communicate effectively with others, unable to demonstrate safe technique for putting out matches or a lighter and also was unsafe while disposing of the ash. He was also assessed to be physically unable to hold the smoking device while smoking. The IDT (interdisciplinary team) determined Resident #40 required constant supervision while smoking with the use of protective gear. A review of Resident #40's Care Plan for smoking dated 08/09/11 when was it last reviewed revealed the problem " the resident is non-compliant with smoking ". The approaches/interventions dated 08/09/11 included resident will smoke in designated areas only, resident will smoke supervised during designated smoking times before and after lunch, staff spoke with family and resident as needed about resident smoking with supervision as needed. An update on 1/23/12 included resident will not have ignition sources in his possession, resident will wear smoking apron when smoking. An updated on 11/08/12 included 15 minute checks will be done round the clock on smoking courtyard to validate that resident is not in courtyard unsupervised. The facility Patient Smoking Acknowledgement dated 10/25/12 was signed by the resident and his family member indicating the understanding of the facility's smoking policy. This was also signed by Social Worker (SW) #1. During an interview with SW #1 on 11/08/12 at	F 323	**3. F323 Measures to be put in place or systemic changes made to ensure practice will not re-occur** -11/8/12 Staff member assigned to smoking courtyard M-F 10am-5pm -11/7/12 Licensed Nurse and or CNA responsible to check smoking courtyard every 15 minute's on Saturday, Sunday and 5pm to 10am M-F to verify that resident #81 and resident #40 are not smoking unsupervised and document finding -All new hires will receive education on smoking policy and 15 minute courtyard checks for smokers identified needing supervision and information provided on Unit Device list. -11/30/12 another meeting held by SW and Administrator with all smokers and their responsible parties to review smoking policy and signed acknowledgements. This included "No resident and/or family members of residents would be permitted to share smoking materials with other residents"	12/07/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 3:44 PM revealed Resident # 40 did not understand the smoking policy so his family member signed the acknowledgment for him to be allowed to smoke. She stated " he cannot tell you he wants to smoke he makes a hand gesture and the staff will take him out to smoke. " She continued, the staff would take him out and stay with him while he smoked. During an interview with the Administrator on 11/07/12 at 3:15 PM she stated " he (Resident # 40) was just out there with a nurse. He must have wheeled himself back out there. " She continued; " he was assessed as an unsafe smoker, we cannot help that other residents can wheel him out there or he wheels himself outside to get a cigarette. He was assigned smoking times to be out there with the staff. " On 11/07/12 at 3:00 PM while interviewing Nurse#1, she interrupted the interview and went out in the smoking courtyard and removed a partially lit cigarette from a resident #40 as he was in the process of (smoking apron noted on the back of wheelchair), lighting a cigarette from (Resident # 81), cigarette butt (approx 1 inch in length) while sitting in the courtyard. As Nurse #1 was taking the partially lit cigarette from Resident #40, Resident #81 grabbed the 1 inch cigarette butt and took a drag from the cigarette butt. Nurse # 1 stated " they are supposed to be supervised when they smoke and there is no staff in the courtyard. " Resident # 40 was noted to have a smoking apron folded on the back of his wheelchair. Nurse #1 repeated resident #40 " is supposed to be constantly supervised and wearing an apron. " She wheeled resident #40 back to the nurses' station leaving resident # 81 in the courtyard smoking his cigarette.	F 323	-Residents identified as needing supervised smoking, designated times, use of apron will be placed on Unit Device list available for all staff daily at nurse's station in folder. -Residents identified as needing supervised smoking will have cigarettes and ignition source kept on nurse's cart. - Care plans for each resident who were assessed as needing supervision when smoking were re-checked and updated on 12/5/12 by Nurse Consultant. -Documentation of 24 hr. 15 minute checks for residents assessed as needing supervision will be reviewed weekly at QA Risk Management meeting, and Quarterly Assurance Committee meeting X 1 quarter for further intervention if needed. **4. F323 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur-** -11/8/12 Staff member assigned to smoking courtyard M-F 10am-5pm	12/07/2012

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	345460	A. BUILDING ______ B. WING ______	11/08/2012

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F 323	Continued From page 11 An interview with the administrator on 11/07/12 at 4:00 PM revealed on 10/25/12 all the residents who were smokers and even all the non smokers were in serviced regarding the new smoking policy and rules. All residents that were smokers were assessed; using a safe smoking assessment and each resident signed the smoking acknowledgement which indicated they were aware of the rules and would follow them. Then all staff and family members including the responsible parties were notified of the smoking policy. The resident's smoking assessments were added to the care plans. They (all residents and families) were told not to share cigarettes, and the ignition sources were all to be kept at the Nurse's station. The staff was supposed to be checking the courtyard every 15 minutes to make sure there is no resident outside who needed constant supervision while smoking. The administrator stated " Resident #40 must have begged Resident # 81 for a cigarette and he gave him one. " She continued the Social Worker spoke with both residents and since they had signed off on the acknowledgement, they will be issued a 30 day d/c (discharge) notice. The family members will be contacted that the residents will be d/c in 30 days. The administrator indicated Resident # 81 told her he took the cigarette butt out of the smoking tower and was smoking it and he did not give a cigarette to Resident # 40. She was unsure how Resident # 81 got the lit cigarette or the cigarette resident # 40 was trying to light. During an interview with Nurse # 2 on 11/07/12 at 3:45 PM she stated she took him (resident #40) outside when he smoked the original cigarettes and she brought him back in and left him in the	F 323	-11/7/12 Licensed Nurse and or CNA responsible to check smoking courtyard every 15 minute's on Saturday, Sunday and 5pm to 10am M-F to verify that resident #81 and resident #40 are not smoking unsupervised and document finding -All new hires will receive education on smoking policy and 15 minute courtyard checks for smokers identified needing supervision, and information provided on Unit Device list. -11/30/12 another meeting held by SW and Administrator with all smokers and their responsible parties to review smoking policy and signed acknowledgements. This included "No resident and/or family members of residents would be permitted to share smoking materials with other residents" -Residents identified as needing supervised smoking, designated times, use of apron will be placed on Unit Device list available for all staff daily at nurse's station in folder.	12/07/2012

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F 323	Continued From page 12 activity room.	F 323	-Residents identified as needing supervised smoking will have cigarettes and ignition source kept on nurse's cart. -Documentation of 24 hr. 15 minute checks for residents assessed as needing supervision will be reviewed weekly at QA Risk Management meeting, and Quarterly Assurance Committee meeting X 1 quarter for further intervention if needed.	12/07/2012
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess potential sedation from medication for 1 of 10 sampled residents (resident #131), and failed to ensure residents were free from excessive dosage of Butrans (buprenorphine), a narcotic analgesic, for 1 of 10	F 329	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	

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F 329	Continued From page 13 sampled residents (resident #27) whose medications were reviewed. Findings include: 1. Resident #131 was admitted to the facility on 7/26/11 with multiple diagnoses including anxiety, insomnia, psychosis, severe dementia with delusional features, and history of falls. Review of the resident's clinical record revealed physician orders dated 8/21/12 for lorazepam (anti-anxiety) 1mg (milligram) topically twice daily, orders dated 4/9/12 for trazodone (antidepressant, sedative) 100mg every night at bedtime, orders dated 9/25/12 to decrease Seroquel (antipsychotic) to 25mg every night at bedtime, and orders dated 7/11/12 for hydroxyzine (antihistamine, sedative) 50mg every night at bedtime, which was discontinued on 10/25/12. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "Ativan (lorazepam) - Warnings/Precautions - use with caution in elderly or debilitated patients...causes CNS depression resulting in sedation, dizziness, confusion, or ataxia. Drug interactions - other CNS depressants may increase the CNS effects of lorazepam. Desyrel (trazodone) - Warnings/Precautions - trazodone frequently causes sedation...sedative effects may be additive with other CNS depressants. Hydroxyzine - Warnings/Precautions - causes sedation...sedative effects of CNS depressants are potentiated. Seroquel (quetiapine) - Adverse effects - greater than 10% - somnolence. Drug interactions - quetiapine increases levels of lorazepam. The effects of other centrally-acting drugs may be potentiated by quetiapine." Review of the minimum data set (MDS) dated	F 329	F329 **How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** Resident #131: MD order dated 11/8/12 to discontinue morning dose of Lorazepam 1 mg. Resident #27: MAR was corrected on 10/20/12 and Medication error report completed 11/2/12.	12/07/2012

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F 329	Continued From page 14 9/18/12 revealed the resident was severely cognitively impaired. The MDS revealed the resident required extensive assistance with his activities of daily living. Review of the resident's care plan dated 9/25/12 revealed approaches which included monitor for adverse reaction to medications (dizziness, drowsiness, orthostatic hypotension, changes in behavior, insomnia). Review of the resident's October 2012 MAR revealed a hand written entry dated 10/3/12 below the lorazepam order which read "hold for sedation." Review of the MAR revealed the 8AM dose of lorazepam was held from 10/4/12 - 10/31/12, as indicated by the nurses' initials being circled. The 9PM dose of lorazepam was held on 10/16/12, 10/18/12, 10/19/12, 10/20/12, 10/21/12, 10/28/12, 10/29/12, and 10/30/12. Review of the MAR revealed Seroquel 25mg was given nightly at 8PM. The MAR revealed trazodone 100mg was given nightly at 10PM. The MAR revealed hydroxyzine 50mg was given nightly at 8PM until it was discontinued on 10/25/12 per the consultant pharmacist' recommendation. Review of the October 2012 nursing notes revealed no documentation regarding the resident's sedation or his lorazepam being held. The nursing notes indicated the resident was "alert and verbal." The nursing notes revealed no documentation of an assessment of the resident's other sedating medications. Observations of the resident on 11/6/12, 11/7/12, and 11/8/12 revealed no signs or symptoms of sedation or other medication side effects.	F 329	**F329 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** All residents who currently received psych meds and Butran patches on 12/06/12 were reviewed for potential adverse medication effects and correct application of the Butran patch by DON. Unit Managers and SDC will be re-educated on Monthly transition of residents' MAR. All residents' medication administration records will be audited during monthly transition of residents' MAR by administrative nursing staff (DON, Unit Managers, and SDC nurse) to ensure accuracy of all physician orders by 12/1/12. Licensed Nurses will be re-educated on MD notification for any residents medication not given for 3 consecutive days. Each Licensed Nurse that was not physically present for in-service will be contacted by telephone.	12/07/2012

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F 329	Continued From page 15 In an interview on 11/8/12 at 3:09PM, Nurse #1 stated if the nurses' initials were circled on the MAR, it meant the medication was held. She reviewed the resident's October MAR and stated the lorazepam was held due to sedation. She wasn't sure what the facility policy was but stated her nursing judgment was to call the physician if a medication was held for three consecutive days. In an interview on 11/8/12 at 3:56PM, the Director of Nursing (DON) stated the nursing staff was trained at orientation by the staff development coordinator. She reviewed the resident's October MAR and stated the nurses' initials being circled meant the medication was held. The facility policy was to notify the physician if a medication was held for three consecutive days. The nursing staff was also supposed to document held doses and sedation in the nursing notes. The DON stated she expected the staff to know the side effects of the medications they administered. Her expectation was for the staff to notify the physician if a resident had continuous sedation. She expected the staff to notify the physician if medication was held for three days. In an interview on 11/8/12 at 5:40PM, one of the nurses responsible for giving the resident's evening medications (Nurse #2) stated the nurses' initials being circled on the MAR indicated the medication was held. She stated the resident's lorazepam was usually given after his other medications. If the resident was asleep she would not awaken him to give the medication. The resident was often awake during the night and sleepy the next morning. The nurse stated she was aware the resident's other medications	F 329	Licensed Nurses will be educated on adverse medication effects with psych meds and the correct application of the Butrans patch. . Each Licensed Nurse that was not physically present for in-service will be contacted by telephone. **F329 Measures to be put in place or systemic changes made to ensure practice will not re-occur:** Transition to electronic MARS will be completed by 12/31/12. Chart Checks will be done daily M-F by Unit Managers to include review of all new orders, discontinued orders and draft orders. DON/and or Unit Managers will audit MAR 10% sample of census X 2 weekly X 4 weeks, X1 weekly X 4, and monthly X 1 for accuracy of MAR and MD notification as needed. Licensed Nurses will be educated on adverse medication effects with psych meds and the correct application of the	12/07/2012

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F 329	Continued From page 16 may also cause sedation. Nurse #2 stated she would hold medication for "3 days at the most, then I'd call the physician." The nurse responsible for giving the resident's morning medications was unavailable for interview. Record review revealed a physician's order dated 11/8/12 to discontinue the morning dose of lorazepam 1mg. 2. Resident #27 was admitted to the facility on 6/30/06 and readmitted on 11/8/10 with multiple diagnoses including rheumatoid arthritis and chronic pain syndrome. Review of the resident's clinical record revealed physician orders dated 7/7/12 for Butrans 10mcg/hr (microgram/hour) apply one patch once weekly and orders dated 9/8/12 for Duragesic 50mcg/hr apply one patch every 72 hours. Butrans and Duragesic are narcotic analgesics indicated for the management of moderate to severe chronic pain. The manufacturer's product information for Butrans read in part: "Administration - each Butrans patch is intended to be worn for 7 days." The product information indicated applying the patch more often than every 7 days may cause accumulation of the medication and an increase in adverse effects. Warnings and Precautions read in part: "additive CNS (central nervous system) effects are expected when used with other opoids. While no dose adjustment is recommended on the basis of age, administer Butrans with caution in elderly patients." Review of the resident's October 2012 medication	F 329	Butrans patch. . Each Licensed Nurse that was not physically present for in-service will be contacted by telephone. **F329 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:** Chart Checks will be done daily M-F by Unit Managers to include review of all new orders, discontinued orders and draft orders. DON/and or Unit Managers will audit MAR 10% sample of census X 2 weekly X 4 weeks, X1 weekly X 4, and monthly X 1 for accuracy of MAR and MD notification as needed. Licensed Nurses will be educated on adverse medication effects with psych meds and the correct application of the Butrans patch. . Each Licensed Nurse that was not physically present for in-service will be contacted by telephone.	12/07/2012

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F 329	Continued From page 17 administration record (MAR) revealed the MAR was blocked off for Butrans to be applied every three days instead of weekly. Review revealed the Butrans patch was applied on 10/2/12, 10/5/12, 10/8/12, 10/14/12, and 10/17/12. The nurse's initials were circled on 10/11/12, indicating the patch was not applied. The MAR was corrected on 10/20/12 and Butrans was applied weekly as ordered on 10/24/12 and 10/31/12. Record review revealed a Medication Error Report for Butrans for resident #27, completed on 11/2/12 by the Director of Nursing. The report indicated Butrans patch was ordered once weekly but was applied every 72 hours. The report indicated there were no observable effects from the medication error. The physician was notified with no new orders given. The report read in part "error made at monthly changeover...difficult to determine specific individual responsible for initial error." Record review of the October 2012 nursing notes revealed no reports of adverse effects from Butrans patch. The nursing staff responsible for administering the Butrans was not available for interview. In an interview on 11/8/12 at 3:24PM, nurse #1 stated the administrative nurses checked the MARS for accuracy at the end of the month. For weekly or other special administration times, the administrative nurses blocked off the MARS on the days the medication was to be given. Nurse #1 stated she double checked her MARS and if they weren't blocked correctly, she blocked them	F 329	Plan of Correction/Audit results to be discussed in weekly QA Risk Management meeting and Quality Assurance Committee meeting X 1 quarter for further intervention if needed.	12/07/2012

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F 329	Continued From page 18 herself. In an interview on 11/8/12 at 4:09PM, the Director of Nursing (DON) stated the MARS were usually checked on the 20-24th of each month by the administrative nurses. First they checked the MARS versus the telephone orders. Then the new MARS were checked against the old MARS. After the second check, all new orders were added to the new MARS. The new MARS were checked and signed by two administrative nurses. For weekly administration, the DON stated the MARS should be blocked off on the days the medication was to be given and X'd out on the days it was not given. The MARS should have been blocked off when they were checked. For new orders, the nurse that took the order was responsible for blocking the MAR. The DON examined the October MAR for resident #27 and stated she was not sure who had checked and blocked the MAR. Her expectation was for the administrative nurses to check the orders and block off the MARS correctly. She expected the nurses that gave the medications to check the directions on the MAR and give medication as ordered.	F 329		12/07/2012
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425		

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F 425	Continued From page 19 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately transcribe physician orders to the medication administration record and monthly physician order sheet for 2 of 10 sampled residents whose medications were reviewed (residents #27, #110). Findings include: 1. Resident #110 was admitted to the facility on 12/8/09 and readmitted on 10/12/12 with multiple diagnoses including coronary artery disease, stent placement, history of cerebrovascular accident, history of peripheral vascular disease, history of carotid disease, and recurrent chest pain. Review of the resident's clinical record revealed physician orders dated 10/12/12 for Plavix 75mg (milligram) daily and Aspirin EC (enteric coated) 325mg one tablet prn (as needed). Plavix and Aspirin are anti-platelet agents used for prophylaxis and treatment of patients at risk for cardiovascular events. Record review revealed physician orders dated 10/21/12 for Aspirin EC 325mg one tablet daily.	F 425	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **F425 How corrective action will be accomplished for each resident found to have been affected by the deficient practice –** Resident #110 ASA order corrected on 11/8/12. Readmitted on 11//19/12 and order dated 11/19/12 for ASA verified as correct. Resident #27: MAR was corrected on 10/20/12 and Medication error report completed 11/2/12.	12/07/2012

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F 425	Continued From page 20 Record review revealed the monthly physician order sheet dated 11/1/12 read "Aspirin EC 325mg one tablet prn." Review of the November 2012 medication administration record (MAR) revealed an entry for Aspirin EC 325mg one tablet prn. Review revealed no aspirin had been administered. In an interview on 11/8/12 at 4:09PM, the Director of Nursing (DON) stated the MARS were usually checked on the 20-24th of each month by the administrative nurses. First they checked the MARS versus the telephone orders. Then the new MARS were checked against the old MARS. After the second check, all new orders were added to the new MARS. The new MARS were checked and signed by two administrative nurses. In an interview on 11/8/12 at 5:18PM, the Director of Nursing (DON) reviewed the November 2012 physician order sheet and MAR and acknowledged the aspirin dosage should have been scheduled rather than as needed. She stated two administrative nurses were supposed to check the physician order sheet and MAR for accuracy. Her expectation was for the monthly physician order sheets and MARS to be correct. 2. Resident #27 was admitted to the facility on 6/30/06 and readmitted on 11/8/10 with multiple diagnoses including rheumatoid arthritis and chronic pain syndrome. Review of the resident's clinical record revealed physician orders dated 7/7/12 for Butrans 10mcg/hr (microgram/hour) apply one patch once weekly. Butrans is a narcotic analgesic indicated for the management	F 425	**F425 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** Unit Managers and SDC will be re-educated on Monthly transition of residents' MAR to include: 1st check to ensure that all telephone orders are on the new mar; block days for medications that are not given daily; checking against last months mar; 2nd check to compare new mar to the old mar and resolve any issues with orders; add any last minute orders. All residents' medication administration records will be audited during monthly transition of residents' MAR by administrative nursing staff (DON, Unit Managers, and SDC nurse) to ensure accuracy of all physician orders by 12/1/12.	12/07/2012

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	345460	A. BUILDING ______ B. WING ______	11/08/2012

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F 425	Continued From page 21 of moderate to severe chronic pain. The manufacturer's product information for Butrans read in part: Administration - each Butrans patch is intended to be worn for 7 days. Review of the resident's October 2012 medication administration record (MAR) revealed the MAR was blocked off for Butrans to be applied every three days instead of weekly. Review revealed the Butrans patch was applied on 10/2/12, 10/5/12, 10/8/12, 10/14/12, and 10/17/12. The nurse's initials were circled on 10/11/12, indicating the patch was not applied. The MAR was corrected on 10/20/12 and Butrans was applied weekly as ordered on 10/24/12 and 10/31/12. Record review revealed a Medication Error Report for Butrans for resident #27, completed on 11/2/12 by the Director of Nursing. The report read in part "error made at monthly changeover...difficult to determine specific individual responsible for initial error." In an interview on 11/8/12 at 3:24PM, nurse #1 stated the administrative nurses checked the MARS for accuracy at the end of the month. For weekly or other special administration times, the administrative nurses blocked off the MARS on the days the medication was to be given. Nurse #1 stated she double checked her MARS and if they weren't blocked correctly, she blocked them herself. In an interview on 11/8/12 at 4:09PM, the Director of Nursing (DON) stated the MARS were usually checked on the 20-24th of each month by the	F 425	**F425 Measures to be put in place or systemic changes made to ensure practice will not re-occur:** Transition to electronic MARS will be completed by 12/31/12. Chart Checks will be done daily M-F by Unit Managers to include review of all new orders, discontinued orders and draft orders. DON/and or Unit Managers will audit MAR 10% sample of census X 2 weekly X 4 weeks, X1 weekly X 4, and monthly X 1 for accuracy of MAR and MD notification as needed. -Unit Managers and SDC will be re-educated on Monthly transition of residents' MAR to include: 1st check to ensure that all telephone orders are on the new mar; block days for medications that are not given daily; checking against last months mar; 2nd check to compare new mar to the old mar and resolve any issues with orders; add any last minute orders.	12/07/2012

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F 425	Continued From page 22 administrative nurses. First they checked the MARS versus the telephone orders. Then the new MARS were checked against the old MARS. After the second check, all new orders were added to the new MARS. The new MARS were checked and signed by two administrative nurses. For weekly administration, the DON stated the MARS should be blocked off on the days the medication was to be given and X'd out on the days it was not given. The MARS should have been blocked off when they were checked. For new orders, the nurse that took the order was responsible for blocking the MAR. The DON examined the October MAR for resident #218 and stated she was not sure who had checked and blocked the MAR. Her expectation was for the administrative nurses to check the orders and block off the MARS correctly.	F 425	**F425 How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:** Chart Checks will be done daily M-F by Unit Managers to include review of all new orders, discontinued orders and draft orders. DON/and or Unit Managers will audit MAR 10% sample of census X 2 weekly X 4 weeks, X1 weekly X 4, and monthly X 1 for accuracy of MAR and MD notification as needed. Plan of Correction/Audit results to be discussed in weekly QA Risk Management meeting and Quality Assurance Committee meeting X 1 quarter for further intervention if needed.	12/07/2012

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	345460	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/06/2012

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V construction utilizing North Carolina Special locking arrangements, and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	01/20/13
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 12/6/2012 the following Life Safety item was observed as noncompliant with the smoke separation for the 200 hallway, specific findings include: The cross corridor doors at the smoke compartment separation had a gap greater than 1/8 of an inch. CFR#: 42 CFR 483.70 (a)	K 027	**K027 How corrective action will be accomplished by the facility to correct the deficient practice –** The cross corridor doors on the 200 Hall, at the smoke compartment separation, will have a door gasket added to close the 1/8 of an inch gap. The door gasket was ordered on December 20, 2012. The door gasket will be replaced by January 20, 2013. **K027 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** All cross corridor doors have been checked and measured and are in compliance. **K027 Measures to be put in place or systemic changes made to ensure practice will not reoccur—** Maintenance Director will inspect during monthly fire drills to ensure corridor doors are sealed properly. **K027 How facility will monitor corrective action(s) to ensure deficient practice will not reoccur:**	
K 047	NFPA 101 LIFE SAFETY CODE STANDARD	K 047		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/31/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 047 SS=D	Continued From page 1 Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 12/6/2012 the following Life Safety item was observed as noncompliant with the exit directional signage, specific findings include: The exit directional signage leading from the lower / East portion of the 100 hallway the 100 hallway nurses station was incomplete as there was no directional sign leading to the lobby corridor. CFR#: 42 CFR 483.70 (a)	K 047	Maintenance Director will inspect during monthly fire drills to ensure corridor doors are sealed properly. We will review findings during quarterly QAA meetings. The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **K047 How corrective action will be accomplished by the facility to correct the deficient practice –** The facility will add an Exit directional sign leading from the lower/East portion of the 100 hallway (the 100 hall nurses station) directing to the Lobby corridor. Directional exit sign has been ordered on December 20, 2012. The sign will be installed by January 20, 2013. **K047 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** All other directional exit signs have been assessed and are in compliance. **K047 Measures to be put in place or systemic changes made to ensure practice will not reoccur—** Maintenance Director will be monitoring daily during inspection rounds to ensure compliance. **K047 How facility will monitor corrective action(s) to ensure deficient practice will not reoccur:** Maintenance Director will be monitoring daily during inspection rounds to ensure compliance. Updates will be provided in quarterly QAA Meeting	01/20/13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		

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K 076	Continued From page 2 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 12/6/2012 the following Life Safety item was observed as noncompliant with the storage of oxygen cylinders, specific findings include: The oxygen cylinders located in the 200 hallway storage room had a mixture of full and empty cylinders on the full oxygen cylinder side of the storage room. CFR#: 42 CFR 483.70 (a)	K 076	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **K076 How corrective action will be accomplished by the facility to correct the deficient practice –** Larger oxygen cylinder racks have been ordered for the 200 Hall storage room, in order to hold and separate all of the empty and full oxygen cylinders. Oxygen cylinder racks will be ordered by December 21, 2012. The larger racks will be in place by January 20, 2013. **K076 How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice –** The Staff Development Coordinator Nurse will in-service staff on the proper storage of oxygen tanks. This will be complete by January 10, 2013. **K076 Measures to be put in place or systemic changes made to ensure practice will not reoccur—** Nursing staff will monitor daily on rounds, during each shift. If there is an issue, it will be addressed immediately. **K076 How facility will monitor corrective action(s) to ensure deficient practice will not reoccur—** Nursing staff will monitor daily on rounds, during each shift. If there is an issue, it will be addressed immediately. Updates will be given at the quarterly QAA Meeting.	01/20/13